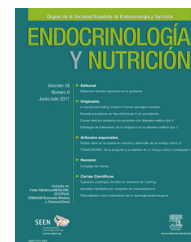




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REVIEW ARTICLE

Psycho-medical care of transsexuals in Spain in the era of depathologization of transsexualism as a mental disorder. An overall review[☆]

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KEYWORDS

Diagnostic and Statistical Manual of Mental Disorders-IV-TR; International Classification of Diseases-10; Standards of care (World Professional Association for Transgender Health 2011); Real life experience; Diagnostic and Statistical Manual of Mental Disorders-5 draft version; Etiology of transsexualism

Abstract

Objective: To identify the strengths and weaknesses of Spanish healthcare protocols for transsexual persons and to compare them to current international protocols. To review the current status as regards transsexuality etiology and prevalence. To suggest measures to optimize care to achieve a significant improvement, including options for saving financial resources.

Methods: A comparison of the contents of texts related to transsexualism in the ICD-10, DSM-IV, and guidelines of the Spanish gender units with international standards of care for transgender persons and the last draft version of the DSM-5. Systematic revision of the literature related to the etiology and prevalence of transsexualism.

Results: Significant discrepancies have been found as regards the minimum time period for diagnosis, access to hormone replacement therapy and to genital surgery, and the requirement of the so-called real-life experience. Impact of sex hormones on the etiology of transsexualism and underestimation of its prevalence was confirmed.

Conclusions: The access to hormonal and surgical treatment requires a profound review, and decentralization of transsexual care is recommended, because all university hospitals have psychiatrists, clinical psychologists, and endocrinologists available. Although gender reassignment surgery also requires plastic surgery specialists, plastic surgeons currently receive training in this field.

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PALABRAS CLAVE

Diagnostic and Statistical Manual of Mental Disorders-IV-TR;

Atención psicomédica a personas transexuales en España en la era de la despatologización de la transexualidad como trastorno mental. Una revisión global

Resumen

Objetivo: Identificar fortalezas y debilidades en los protocolos españoles de atención sanitaria a personas transexuales y compararlos con los estándares internacionales actuales.

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Clasificación internacional de enfermedades-10; Estándares de cuidado (World Professional Association for Transgender Health 2011); Experiencia de vida real; Borrador Diagnostic and Statistical Manual of Mental Disorders-5; Etiología de la transexualidad

Revisar el estado actual de la etiología y prevalencia de la transexualidad. Sugerir medidas para optimizar esta atención en vistas a una mejora significativa, incluyendo opciones de ahorro de recursos financieros.

Métodos: Comparación entre los contenidos relacionados con la transexualidad incluidos en la CIE-10, el DSM-IV y los protocolos españoles de las unidades de (trastornos de) identidad de género, los estándares internacionales para el cuidado de personas transgénero y el último borrador del DSM-5. Revisión sistemática de la literatura relacionada con la etiología y la prevalencia de la transexualidad.

Resultados: Se han identificado discrepancias significativas respecto al periodo mínimo de diagnóstico, el acceso a la terapia sustitutiva hormonal y el acceso a las cirugías genitales, así como a la exigencia de la experiencia de vida real. Se ha comprobado el impacto hormonal sobre la etiología de la transexualidad, y la infraestimación de su prevalencia. Se desestima la exigencia del tratamiento exclusivamente en unidades funcionales por carecer de justificación médica.

Conclusiones: El acceso al tratamiento endocrinológico y quirúrgico requiere una revisión profunda y se recomienda la descentralización de la atención a personas transexuales, ya que todos los hospitales universitarios disponen de psiquiatras, psicólogos clínicos y endocrinólogos. Aunque las cirugías de reasignación de género precisan además de cirujanos plásticos, su formación actual ya incluye esta especialidad.

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Background

On September 28, 2011 the European Parliament passed a resolution on sexual orientation and gender identity, binding for all Member States, which stated in point 13 that the EU

“Roundly condemns the fact that homosexuality, bisexuality and transsexuality are still regarded as mental illnesses by some countries, including within the EU, and calls on states to combat this; calls in particular for the depsychiatrization of the transsexual, transgender, journey, for free choice of care providers, for changing identity to be simplified, and for costs to be met by social security schemes.”¹

In this sociopolitical context, we have already begun to make substantial progress as regards the reformulation of Spanish standards and protocols for the care of transsexual people in multiple aspects, including the depathologization of transsexualism in general, which has already been approved by different European parliaments, including the Spanish Parliament (15/03/2010) and the parliaments of some of its autonomous communities.

The diagnostic criteria in the drafts of the fifth edition of The Diagnostic and Statistical Manual of Mental Disorders (DSM-5), issued in December 2010 by the American Psychiatric Association (APA),² which include the replacement of the term gender identity disorder (GIT) by gender identity dysphoria (GID) and so represent a partial elimination of the prior mental pathologization³ are however more relevant, although still insufficient in some aspects. The previous title has also been replaced by a more adequate one, and the subtyping of sexual orientation and autogynephilia, amongst others, has been deleted.

Almost the same may be said about the renewal of the catalog published by the WHO, especially section F64 of ICD-10,⁴ although it was not made clear in what new context

transsexualism would be classified after being removed from the list of mental disorders.⁵

On the other hand, it should be noted that definitions of transsexualism in DSM-IV and F64.0 of ICD-10 of the WHO were old definitions, subsumed as mental illnesses, i.e. they followed exclusively formal and administrative, even pathologizing, criteria with regard to the diagnosis of transsexualism. In any case, physicians are expected to have sufficiently up-to-date knowledge of their respective disciplines to be able to adequately investigate the clinical history of, to diagnose, and to treat their patients.

Almost at the same time as the DSM-5 drafts and after its sixth version, published in 2011,⁶ the World Professional Association for Transgender Health (WPATH) issued the seventh version of its Standards of Care (SOC).⁷ The most novel and important aspect of this version is that the psychiatrist or clinical psychologist, apart from diagnosis, should counsel patients in order to facilitate the transition as far as possible.

A comparison of what are considered to be necessary preconditions for patient access to so-called cross-sex hormone therapy and to sex reassignment surgery (SRS) following a positive evaluation of GD and a confirmation of eligibility by the mental health specialist, as defined in the sixth and seventh versions of the SOC (2001 versus 2011) from the WPATH,^{6,7} reveals significant changes.

SOC-6 (2001)⁶ required living three months in the desired opposite sex (real-life experience) or having experienced three months of psychotherapy before hormone administration, in addition to diagnosis and recommendation by a clinical specialist. For SRS, in addition to recommendation by the mental health specialist, a year living in the desired sex role was required. That is, the complete process could last one year, or a little longer.

In SOC-7 (2011),⁷ the recommended eligibility criteria for feminizing/masculinizing hormone therapy were updated as follows: a positive evaluation of GID that allows

for confirming eligibility for hormone therapy, together with patient consent, in a letter addressed to the endocrinologist. Telephone confirmation from the mental health specialist is also requested if this specialist is not part of a multidisciplinary team from the same hospital. A period of real-life experience is not now required, because this term has been deleted from the new SOC. Eligibility for access to relatively minor surgeries (mastectomy or mastopexy) requires documentation accrediting persistent GID, patient capacity to take informed decisions, minimum age (depending on the country) and, if concomitant psychopathology exists, that this is well controlled. No hormone therapy is required in the event of mastectomy. Patients who desire a mastopexy are recommended to have at least 12 months of hormone therapy to adequately develop the breasts.

There are different requirements for SRS depending on the surgical procedure. Ovariohysterectomy and orchiectomy require two separate Psycho-medical reports and uninterrupted hormone therapy for 12 months, except if the patient has any medical contraindication, is reluctant to have hormone administration, or has no means of obtaining it. A period spent living in a desired sex role is not required for this SRS. By contrast, for access to genital SRS (phalloplasty or vaginoplasty), apart from an evaluation of GID and continuous 12-month cross-sex hormone therapy, uninterrupted life for one year in the gender role consistent with gender identity of the patient is required. The whole process (GID evaluation, the cross-sex hormone therapy phase, and living in the desired role) may be completed in one year, provided the different members of the multidisciplinary Psycho-medical team closely collaborate with each other and with the patient.

Another new criterion in SOC-7 to be highlighted, resulting from the extensive clinical, scientific, and psychological research made over the intervening decade, is that living in a classical-stereotypical role of one of the two opposite sexes is no longer required. A non-binary gender role may be accepted. This gives the patient more dignity, autonomy, and freedom to decide. In the author's opinion, almost the only deficiency in the seventh version of SOC is a possible lack of consideration of the personal circumstances of the patient, such as the risk of employment loss or family or social conditions that may not allow him/her for a time to live openly in the desired identity, even if hormone therapy is administered and/or SRS, even genital, is performed, despite the relief thereby obtained.⁸

In order to correct a national structural deficiency, the so-called comprehensive transsexuality acts have been approved in the mean time. The Navarre act was first approved in 2009,⁹ while the Basque Country act was approved on 28 June 2012.¹⁰ An act is now being debated in the Region of Murcia,¹¹ while the Andalusian act is still in the planning phase.¹² The purpose of these acts is to revise the already available or newly prepared clinical guidelines in collaboration with representatives from the associations and/or societies of transsexual people, following the international standards issued by the WPATH,⁷ i.e. SOC-7. These comprehensive acts also regulate the educational aspects, occupational (re)integration, and administrative

support, amongst others, and demand respect for the dignity and autonomy of the transsexual person in all of these aspects.

The new 2012 version of the Spanish Guide for the Care of Transsexual People,¹³ an update of the first version published in 2003¹⁴ (internal versions have been available since 2001), is characterized by a wealth of data and multiple explanations and repetitions where they are considered necessary. In addition, it is written in a language intended not only for colleagues, but also for specialists in clinical psychology and psychiatry, plastic surgeons, and technical and nursing staff, amongst others. As regards plastic surgeons, the Order SAS/1257/2010,¹⁵ issued two years ago, plans for this highly specialized group professional training including the genital reconstruction of transsexual people, among other highly complex procedures. This is intended to guarantee complete national coverage as part of the future optimization of health care for transsexual people, and represents the first step toward the decentralization of surgical care in this field at state level. This should be complemented with mutual recognition of clinical results by the different hospitals, thus reducing the long journeys required by the need for patient referral to the currently limited number of reference centers in Spain. The long waiting lists should also be reduced, thus preventing the development of potential additional psychopathologies in these patients. This set of measures would also decrease the total costs involved in the care of transsexual people.

With regard to the etiology of transsexualism, the influence of sex steroids on brain development and function is extremely important, as has been clearly demonstrated by several scientific studies.¹⁶ In fact, various analyses using magnetic resonance imaging (MRI) show a clear association between brain areas that may be related to the effect of estrogens on brain development. This conclusion is based on a clear correlation of parameters between biological women and m > f (male > female) transsexual people, but statistical confirmation is still required because the number of studies so far conducted cannot be considered sufficient. A study conducted by the Netherlands Institute for Brain Research and the Free University of Amsterdam identified structural similarities in brains from transsexual and biological (heterosexual) females.¹⁷ A second study provided identical results including additional controls which resolved the potential methodological shortcomings of the previous one.¹⁸ A subsequent recent study by the Department of Clinical Neuroscience of the Stockholm Brain Institute, conducted on 48 heterosexual males and females (not transsexual) and 24 transsexual females (m > f), did not support the previous findings.¹⁹ However, the results reported by Luders et al.,²⁰ very similar to those achieved in 1995 and 2000 by the Swaab group,^{16,17} provided clear evidence that transsexualism manifested in transsexual women is associated with morphological brain differences. These results have been confirmed by an analysis of reactions localized in the brain in electroencephalogram (EEG) studies demonstrating that brains from the m > f transsexual group had greater similarities to brains from the group of heterosexual women (cissexual or not transsexual) as compared to the male group.²¹ A recent study at Barcelona University (2011) supported

these findings,²² and the Gender Identity Disorder Unit (UTIG) in Madrid accepts the largely confirmed hypothesis that the etiology of transsexualism is based on neurobiological sex differentiation.²³

Conclusions

The waiting lists for and the overall costs of the treatment of transsexual individuals could be substantially reduced if the new SOC from the WPATH was used as a guide with the flexibility needed for patient well-being, rather than merely as a legal regulation. It would also be very helpful to achieve mutual recognition of the results of clinical laboratory tests throughout Spain. This would also decrease the chances of the secondary development of new psychopathologies, a potential consequence of a health care process at U(T)IGs that usually lasts approximately four years from the first visit to genital SRS.

In this context, the APA's attempt at developing its own complementary guidelines for the treatment of problems associated with gender identity (still considered in this publication as gender identity disorders [GID] of transsexual individuals,²⁴ although the term has currently been replaced by GID) is highly significant. In fact, SOC-7 issued by the WPATH (although the APA task force²⁴ still refers to the sixth version of the SOC issued in 2001) shows a clear trend to the depathologization of transsexualism, with increased autonomy and freedom of choice for transsexual individuals. By contrast, the positioning of the WHO in the future ICD-11, as mentioned by the three authors in their role of members of the Working Group on the Classification of Sexual Disorders and Sexual Health, is still not clear.²⁵

Conflict of interest

The author states that she has no conflict of interest.

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